SHARE PROGRAM AED USE DATA FORM
Bureau of Emergency Medical Services
Arizona Department of Health Services

Property/Business/Individual Name: _____

Incident Date: _____ / _____ / _____ Estimated Time of Collapse: _____

Patient Name: _____

Gender: M ☐ F ☐ Age: _____

Employee ☐ Customer ☐ Guest ☐ Employee Family ☐

Other, please specify: _____

1. Where on your property did this incident occur? _____
   (i.e. kitchen, lobby, single office, outdoor grounds, restroom, 6th hole, club house, etc.)
2. Was this incident witnessed by anyone? YES ☐ NO ☐
3. Who witnessed? Employee/Co-worker ☐ Friend ☐ Family ☐ Stranger ☐
   Doctor/Nurse/Paramedic ☐ Other: _____
4. Was CPR or CCC performed before the AED was connected to the patient? CPR ☐ CCC ☐
5. Did the AED instruct you to shock? YES ☐ NO ☐ If yes, number of shocks _____
6. Was the patient transported from your property by ambulance? YES ☐ NO ☐
   If yes, which Fire Department or Ambulance Company: _____
7. Name of destination hospital, if known: _____
8. Did the patient exhibit any of the following after collapse and prior to departure from your property?
   Pulse ☐ Breathing on own ☐ Eye opening ☐ Confusion/combativeness ☐
   Vomiting ☐ Moving arms/legs ☐ Talking ☐
9. Do you have any questions or would you like to review this AED use with the BEMS medical direction representative? YES ☐ NO ☐

Person completing form: _____

Telephone Number: _____ Best time to call you: _____

Please fax completed form to: Lani Clark at (520) 626-2201.

Revised: 1/31/05